SECTION 2

RURAL HEALTH CLINIC SERVICES

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1 GENERAL POLICY

Rural Health Clinic services are primarily ambulatory, outpatient office type services furnished by physicians and other approved providers at a Rural Health Clinic, located in a rural area that has been designated as a shortage area by the Bureau of the Census and has been certified for participation in Medicare in accordance with 42 CFR Part 405, Subpart X and 42 CFR Part 491, Subpart A. A clinic certified under Medicare will be deemed to meet the standards for certification under Medicaid.

The clinic or center must be under the medical direction of a physician and have a health care staff that includes one or more physicians and one or more nurse practitioners or physician assistants. The staff may also include ancillary personnel who are supervised by the professional staff. The staff must be sufficient in numbers to provide the services essential to the operation of the clinic or the center. A physician, nurse practitioner, nurse midwife or physician assistant must be available to furnish patient care services at all times the clinic or center operates.

The Rural Health Clinic and clinic staff must be in compliance with applicable federal, state and local laws for licensure, certification and/or registration.

Authority for Rural Health Clinic services is found at Sections 1861(aa), 1102 and 1871, of the Social Security Act, and at 42 CFR Part 405, Subpart X; 42 CFR Section 440.20(b); and 42 CFR Part 491, Subpart A.

1 - 1 Clients Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed care plan, such as a health maintenance organization (HMO) or Prepaid Mental Health Plan (PMHP), must receive all health care services through that plan. Refer to SECTION 1 of this manual, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan. For more information about managed health care plans, please refer to SECTION 1, Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of HMOs and PMHPs with which Medicaid has a contract to provide health care services is included as an attachment to this provider manual. Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. Because eligibility information as to which plan the patient must use is available to providers, a "fee for service" claim will not be paid even when information is given in error by Medicaid staff.

1 - 2 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 3 Billing

Services may be billed electronically or on paper, using the HCFA-1500 claim format. Medicaid encourages electronic billing. Mistakes can be corrected immediately, and claims are processed without delays. Electronic claims may be submitted until noon on Friday for processing that week. Refer to SECTION 1 of this manual, Chapter 11, for more information on billing claims.

1 - 4 Definitions

Definitions of terms used in multiple Medicaid programs are in SECTION 1 of this manual, Chapter 13, Definitions. Definitions particular to rural health clinic services are below.

Direct Service

Services provided by the clinic staff.

Home Care recipient

A recipient who is temporarily or permanently confined to his place of residence, only able to leave infrequently for short periods of time because of the limitation of a medical or health condition and/or the need for special equipment or assistance. The limited status qualifies the recipient for visiting nurse service provided in the home by the clinic when the home is the most appropriate setting consistent with the client's medical need. Place of residence does not include a hospital or nursing facility.

Nurse Midwife

A registered professional nurse who meets the following requirements:

(1) is currently licensed to practice in the state as a registered professional nurse.

(2) is legally authorized under state law or regulation to practice as a nurse-midwife.

(3) has completed a program of study and clinical experience for nurse-midwives, as specified by the state.

Nurse Practitioner

A registered professional nurse who meets the state's advanced educational and clinical practice requirements beyond the basic nursing education, and

(1) is currently licensed to practice in the state as a registered professional nurse, and

(2) meets the state requirements for qualification as a family or pediatric nurse.

Reference: 42 CFR 440.166; 42 CFR 491.2

Other Ambulatory Services

Ambulatory services other than those specifically identified as rural health clinic services that are otherwise included in the State Plan can be provided at the clinic. These services must be provided under the single rate per visit that is based on the cost of all services furnished by the clinic.

Physician Assistant

A person who meets the applicable state requirements governing the qualifications for assistants to primary care physicians, and who meets at least one of the following conditions:

(1) is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or

(2) has satisfactorily completed a program for preparing physician's assistants that:

a. was at least one-academic year in length;

b. consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care;

and

c. was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

(3) has satisfactorily completed a formal educational program (for preparing physician assistants) that does not meet the requirements of paragraph (2) of this section and assisted primary care physicians for a total of 12 months during the 18-month period that ended on December 31, 1986. Reference: 42 CFR 491.2

Physician Services

Service provided:

(1) within the scope of practice of medicine or osteopathy; and

(2) by or under the personal supervision of an individual licensed to practice medicine or osteopathy whether furnished in the office, the home, a hospital or elsewhere.

Physician Supervision

To observe and oversee the work and performance of ancillary staff, including physician assistants, to assure that the health, safety and welfare of patients is not compromised.

Plan of Treatment

A written plan of care/service for part-time or intermittent visiting nurse service that is established and reviewed at least every 60 days by the supervising physician at the clinic.

Primary Care

The ambulatory, outpatient, office type care provided by the clinic's professional staff and, where appropriate, the supplies commonly used to support those services, CLIA approved laboratory services essential for diagnosis and treatment, and emergency medical care for the treatment of life-threatening injuries and acute illness.

Rural Area

An area that is not delineated as an urbanized area by the Bureau of the Census.

Rural Health Clinic or "Clinic"

A facility that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements of this subpart to provide Rural Health Clinic Services under Medicare.

Secretary

Secretary of Health and Human Services, or any official to whom he has delegated the pertinent authority.

Shortage Area

A defined geographic area designated by the Department as having either a shortage of personal health services (under section 1302(7) of the Public Health Service Act) or a shortage of primary medical care manpower (under section 332 of that Act).

Visit

A face-to-face encounter between a clinic patient and any health professional whose services are reimbursed under the State Plan. Encounters with more than one health professional and multiple encounters with the same health care professional , that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

Visiting Nurse Services

Part-time or intermittent service provided to a clinic service recipient by a Rural Health Clinic located in an area in which the Secretary has determined that there is a shortage of home health agencies. The service must be provided by a registered nurse or licensed practical nurse employed by, or otherwise compensated for the service by the clinic.

1 - 5 Co-payment Requirement

Effective April 1, 2002, many adult Medicaid clients will be required to make a $2.00 co-payment for services in a Rural Health Clinic. Both managed care and fee-for-service clients can have a co-pay. The client's Medicaid Identification Card will state when a co-payment is required and for what type of services. The provider is responsible to collect the co-payment at the time of service or bill the client. Rural Health Clinic "encounter rates" will be prospectively adjusted to reflect these co-payments. Therefore, no message regarding co-payments will appear on the clinics' remittance statements.

For general information about the co-payment requirement, clients required to make a co-pay, exempt clients, and an example of the co-payment message on the Medicaid Identification Card, refer to SECTION 1 of this manual, GENERAL INFORMATION, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3, Medicaid Co-payments.

A. Clients Exempt from Co-payments

If there is not a co-payment message under a client's name, the client does not have a co-payment. Also, do not require a co-payment for services to a pregnant woman, even if there is a co-pay message by her name on the Medicaid Identification Card. Add pregnancy diagnosis V22.2 to the claim. Encourage the woman to report her pregnancy to the Medicaid eligibility worker, who can change her co-pay status to exempt on future Medicaid cards.

B. Services Exempt from Co-payments

Clients are not required to make a co-payment for the following types of services:

1. Family planning services.
2. Emergency services in a hospital emergency department.
3. Lab and X-ray services, including both technical and professional components.
4. Anesthesia services.

C. Co-payment per Medical Visit

Except for exempt clients and exempt services described in items A and B above, Medicaid clients have a co-payment for services in a Rural Health Clinic.

2 COVERED SERVICES

Services provided at the Rural Health Clinic or center are primarily outpatient health care services and must be provided in accordance with applicable federal, state and local laws. Written policies developed by a group of professionals from the clinic, and at least one member from outside the clinic staff, governs the clinic operation and service delivery. The policies describe the services the clinic or center furnishes directly or through agreement; guidelines for the medical management of health problems, including those conditions requiring medical consultation and/or patient referral; management of health care records; and rules for storage, handling and administration of drugs and biologicals. Policies include provisions for a periodic review and evaluation of the clinic services.

The core Rural Health Clinic services include:

A. Physician services which are ambulatory, outpatient, primary care services provided by physicians, nurse practitioners, nurse midwives, or physician assistants, within the licensed scope of practice of their respective professions.

The general physician supervision policy applies to provision of Rural Health Clinic Services:

1. Physician services must be personally rendered by a physician licensed under state law to practice medicine or osteopathy, or by an individual licensed to serve the health care needs of a practice population under a physician's supervision.

2. The acceptable standard for supervision is availability by telephone. When the physician maintains written protocols embodying care standards and supervisory procedures along with appropriate Delegation of Services Agreements maintained at the practice site. Medical records must have sufficient documentation signed by a physician to reflect active participation of the physician in supervision and review of services provided by staff under supervision.

B. Services and supplies furnished incident to the professional services of physicians, nurse practitioner, nurse midwife, physician assistant, or other specialized provider in order to provide necessary medical care.

The service or supply should be:

1. of the type commonly furnished in a physician's office and would be covered if furnished directly by the physician,

2. of a type rendered either without charge or included in the Rural Health Clinic bill,

3. furnished as an incidental, although integral, part of a physician's professional service,

4. furnished under the direct personal supervision of a physician or other professional staff by an employee of the clinic, (which may include non physician service like health behavior assessment code 96150 through 96155).

5. drugs and biologicals furnished "incident to" the physician's professional services, are included within the scope of the program provided they cannot be self administered by the recipient.

C. Basic laboratory services essential for the immediate diagnosis and treatment of illness or injury. In order to qualify for reimbursement, laboratory services must be in compliance with the rules implementing CLIA and any amendments thereto.

D. Part-time or intermittent visiting nurse service and related medical supplies, other than drugs and biologicals, if the clinic is located in an area in which the Secretary has determined that there is a shortage of home health agencies. Visiting nurse service would be covered if:

1. A registered nurse or licensed practical nurse who is employed by or otherwise receives compensation for the service from the clinic provides the service to a recipient in his place of residence.

2. The service is provided in accordance with a written plan of treatment, reviewed at least every 60 days by a supervising physician at the clinic.

3. The client's record clearly shows that the services would not otherwise be available.

E. Other ambulatory services which are otherwise provided in the State Plan. Service must meet all requirements of the State Plan and provider eligibility.

F. Emergency medical care as a first response to common life-threatening injuries and acute illness. Drugs and biologicals commonly used in life saving procedures such as analgesics, anesthetics, (local), antibiotics, anticonvulsants, antidotes, and emetics, serums, and toxoids must be available.

3 LIMITATIONS

1. Rural Health Clinics will only be reimbursed for one encounter per day. Encounters with more than one health professional, and multiple encounters with the same health professional, which take place on the same day constitute a single visit. The provider may bill up to, but not exceeding, the established encounter rate.

2. An individual encounter rate is established for each Rural Health Clinic according to policy outlined in Chapter 6. The encounter rate will be a blended rate of all service costs, exclusive of costs or encounters for carve-out services. If a Rural Health Clinic itemizes multiple services provided to a single patient at a single location on the same day, payment will be made at the established encounter rate regardless of the total claim.

   In the event that a recipient, subsequent to the first encounter, suffers a second spell of illness or injury, unrelated to the first incident, which is identified by a different diagnosis and/or treatment, a second encounter may be billed.

4 NON-COVERED SERVICES

1. Personal care services are not a benefit of the Medicaid program and are not covered under visiting nurse services for Rural Health Clinics.

2. Homemaker or chore services are not covered under the Medicaid program.

5 BILLING CODE

Use one of the following codes to bill covered services in a Rural Health Clinic, depending on date of service.

Y0099 Encounter, Rural Health Clinic. For date of service before April 1, 2002.

T1015 Encounter, Rural Health Clinic. For date of service on or after April 1, 2002.

4 PROSPECTIVE PAYMENT SYSTEM

The Utah Department of Health, Division of Health Care Financing, (hereafter referred to as "the Department") will implement, effective January 1, 2001, the Prospective Payment System (PPS) for Rural Health Clinics (RHC) as described at Section 1902(a) of the Social Security Act, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, (H.R. 5661 as incorporated into the Consolidated Appropriations Act, 2001), (PubLNo106-554).

The base encounter rate will be an average of each RHC's fiscal year costs for years 1999 and 2000, adjusted by the Medicare Economic Index (MEI) for each respective year, divided by the total encounters for those same years. The encounter rate will be a blended rate of all service costs (e.g., medical, dental, etc.), exclusive of costs or encounters for carve-out services. Adjustments to the encounter rate will be made in subsequent years by the application of the MEI and any changes in scope as described below.

RHCs will submit annually to the Department their Medicare Cost Report, trial balances, annual independent audit, and other supplementary information as requested and mutually agreed upon, in order to substantiate the fiscal integrity of each RHC as a Medicaid contractor.

The Department will provide to each RHC on an annual basis notification of the adjusted PPS reimbursement rate and HMO/carve-out encounter and payment data. Additionally, the Department will document the RHC Prospective Payment System within the Medicaid Provider Manual, including subsequent amendments.

Scope of Service Changes

RHCs may request, no more than once per quarter, that PPS payment rates be adjusted for any increases or decreases in the scope of service. A change in the scope of service in an RHC can reflect the addition or deletion of an RHC -covered service or a change in the intensity, duration, amount and/or character of currently offered services. The Department will review, prior to approval, all requests to ensure compliance to the Medicare regulations relative to these changes. The review may take place up to one year after the Department allows the change on an interim basis.

Providers must submit the RHC Application for PPS Change in Scope which substantiates the changes and the increase/decrease in costs related to these changes, following Medicare principles of reasonable cost reimbursement. The changes must be significant, with substantial increases/decreases in costs, and documentation must include data to support the calculation of an adjustment to the PPS rate. The cost impact must be material and significant: greater than 1% of the RHC's per encounter costs.

Scope Change Adjustment Process

1. RHCs, at their initiation, will notify the Department in writing within 90 days of the effective date of any changes in scope of service and explain the reasons for the change. Any adjustment in encounter rate will be effective for services performed after the date of the change in the scope of services.

2. RHCs will submit the RHC Application for PPS Change in Scope which substantiates the changes and the increase/decrease in costs, following Medicare principles of reasonable cost reimbursement, related to these changes.

3. RHCs will be notified in writing by the Department within 30 days of any adjustment to the rate following a review of the submitted Application for PPS Change in Scope.

4. RHCs may appeal the Department's determination for an adjustment or the amount of the adjustment in accordance with the procedural requirements contained in the Medicaid Provider Manual.

5. For changes in scope that occurred in an RHC's fiscal years 2001 and until PPS implementation in 2002, the above described process will apply.

6. The Department reserves the right to adjust the encounter rate for any scope of change that comes to its attention.

Claims Process

Effective April 1, 2002, for RHCs, all medical claims will be submitted on Form HCFA 1500 [CMS 1500] using the encounter code "T1015". Until further notice, claims for dental services will continue to be submitted on the ADA Dental claim form as currently done. PPS will not be effective for dental claims until the Department can perform additional system programming to accommodate the ADA dental form.

Rate Determination for New RHCs

Newly qualified RHCs after fiscal year 2000 will have initial payments established either by reference to payments to other clinics in the same or adjacent areas, or in the absence of other clinics, through cost reporting methods. This initial payment will be considered an approximation of the provider's cost and will be adjusted after the first full twelve month cost report is submitted. This first period of operation therefore will be paid based upon an allowable cost basis. Once the first full year cost report has been received and reviewed the PPS rate effective for the provider will be the basis of all future payments. New RHCs lacking actual fiscal reports due to no or limited service delivery will submit the RHC Application for PPS Change in Scope. The Department will recognize the capital and other start-up costs documented on the schedule in determining the initial PPS rate. Startup costs will be amortized over an estimated useful life not to be less than five years. Actual costs incurred will be reported at the end of the first year of operation and will form the basis for the calculation of the subsequent PPS rate.

After the initial year, the provider's payment rates shall be adjusted to reflect the change in the MEI.

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